Efalizumab (Raptiva™) Prior Authorization Request Form

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE Mail Order Pharmacy (TMOP) *OR* the TRICARE Retail Pharmacy Program (TRRx). Express Scripts is the TMOP and TRRx contractor for DoD.

MAIL ORDER	**IF the prescription is to be filled through the TRICARE Mail Order Pharmacy, check here** ☐	**RETAIL**	**IF the prescription is to be filled at a retail pharmacy under the TRICARE Retail Pharmacy Program, check here** ☐
	• The provider should complete the form, sign, and date • The provider may **fax** the completed form and the prescription to **1-877-895-1900** or 1-602-586-3911 (commercial) **OR** • The patient may attach the completed request form to the prescription and **mail** it to the TMOP at: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954**		To request prior authorization, the provider may **call** this number: • **1-866-684-4488** OR • The provider may complete the form, sign, date, and **fax** to **1-866-684-4477**

Prior authorization criteria and a copy of this form are available at: http://www.tricare.osd.mil/pharmacy/prior_auth.cfm. This prior authorization has no expiration date.

Drug for which Prior Authorization is requested: Efalizumab (Raptiva™)

Step 1 **Please complete patient and physician information** (Please Print)

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID #: _____ Phone #: _____

Secure Fax #: _____

Step 2 **Please complete the clinical assessment**

1. Does the patient have atopic asthma or psoriatic arthritis without plaque psoriasis, or is the patient immunosuppressed due to renal transplantation or other etiology, or is the patient a child (<18 years old)?	☐ Yes Coverage not approved	☐ No Please proceed to Question 2
2. Will the patient receive concomitant therapy with another immunosuppressive agent?	☐ Yes Coverage not approved	☐ No Please proceed to Question 3
3. Does the patient have chronic (> 6 months), moderate to severe plaque psoriasis with a minimum body surface area involvement of 10%?	☐ Yes Please proceed to Question 5	☐ No Please proceed to Question 4
4. If the body surface area is less than 10%, but in critical areas, e.g. palms, soles, or face, does the patient's psoriasis interfere with day-to-day activities?	☐ Yes Please proceed to Question 5	☐ No Coverage not approved
5. Is the patient a candidate for phototherapy or systemic therapy?	☐ Yes Please proceed to Question 6	☐ No Please proceed to Question 7
6. Has the patient tried and failed traditional therapy, such as phototherapy (e.g., UVB, PUVA) or systemic therapy (e.g., methotrexate, acitretin, cyclosporine)?	☐ Yes Please proceed to Question 7	☐ No Coverage not approved
7. Does a dermatologist recommend therapeutic intervention with efalizumab for this patient?	☐ Yes Coverage approved	☐ No Coverage not approved

Step 3 **I certify the above is correct and accurate to the best of my knowledge.**
Please sign and date:

_____ _____

Prescriber Signature Date

Latest revision: July 2005